DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2014 FORM APPROVED OMB NO. 0938-0391

Name of Promiber or Supplier Street Address, City, STATE, 2P CODE 131 HARCOURT TERRACE NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, 2P CODE 131 HARCOURT RD 131 HARCOURT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID (X4) ID (X5) ID (X6) ID (X6								
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS This visit was for the investigation of Complaint IN00140941. This visit was in conjunction with the recertification and State Licensure survey. This visit was in conjunction with the investigation of Complaint IN00140941. Complaint IN00140941: Unsubstantiated due to lack of evidence. Survey dates: December 2, 3, 4, 5, 6 & 10, 2013 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Survey team: Gloria Bond, RN Team Coordinator Janet Stanton, RN Sandra Nolder, RN Census bed type: SNF: 8 SNF:NF: 8 SNF:NF: 86 Total: 94 Census payor type: Medicare: 12 Medicard: 72 Other: 10 Total: 94	NAME OF PROVIDER OR SUPPLIER				8181 HARCOURT RD	CODE	12/10/2013	
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Harcourt Terrace Nursing and Rehabilitation was		Harcourt Terrace Nur	sing and Rehabilitation was					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

E (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		155149	B. WING			C 12/10/2013	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		2/10/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	found to be in complia Subpart B and 410 IA investigation of Comp	ance with 42 CFR Part 483, C 16.2 in regard to the plaint IN00140941.	FO	,			